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ABSTRACT

This paper examines the variety of legal rules and processes which have been established to assess and ensure that the quality of care provided in nursing homes satisfies an acceptable level. It begins with a general overview of nursing home law. Areas discussed in this section include: (1) sources of nursing home law; (2) theories of liability; and (3) personal, vicarious, and corporate liability. The next section pays specific attention to the rights of nursing home residents. Sources of resident rights are explained, substantive provisions are discussed, and resident rights advocacy efforts are described. The third section of the paper concerns decision making for nursing home residents. The issue of competent residents and informed consent is examined, determination of competency is explained, and proxy decision making for incompetent residents is discussed. Ths issue of "Do Not" orders, decisions to withhold or withdraw certain types of medical interventions from a resident made by the attending physician, is also addressed. The final section provides speculation about the future of nursing home law. Thirteen pages of references are included. (NB)

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LEGAL ISSUES IN NURSING HOMES

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Residents and potential residents, as well as their families, friends, and advocates, are vitally interested in the quality of care that is available in our nation's nursing homes. So, too, is the general public. As a reflection of that legitimate concern by society, we have devised a variety of legal rules and processes to assess and ensure that the quality of care provided in nursing homes satisfies an acceptable level.

The pervasiveness of legal regulation affects administrators and professional staff working within nursing homes perhaps even more extensively than it influences other types of health care providers. While most applicable legal issues are basically generic to the entire health care sphere, there are certain unique characteristics of both nursing homes and their residents that may have an impact of respective legal rights and duties. Nursing homes are health care institutions, but they are also total living institutions with other functions as well. Most of the persons who reside in nursing homes are seriously compromised by physical or mental disabilities, and the strong trend is toward an older and sicker nursing home population. These factors complicate the way that the law defines the relationship between nursing home, resident, and others, and the manner in which the law seeks to resolve potential differences between these parties.

Another potential influential factor is the growing phenomenon of the "teaching nursing home". Nursing home affiliation with health professions education programs may range in complexity and formality from an occasional visit by a medical student or a medical resident in a small, community-based facility to highly organized collaborative research projects involving significant medical interventions with large numbers of human subjects. Among the many possible legal issues implicated by such affiliations and associated activities are: informed consent for research participation and

for treatment by students and postgraduate trainees, the need for an Institutional Review Board if either the nursing home or the affiliated educational institution conducts human subject research sponsored in any part by federal money, maintaining acceptable standards of care by all participants and consequent shared liability for substandard care, and confidentiality. Because the "teaching nursing home" phenomenon has developed in earnest only recently, little specific substantive law has been forged yet in this area. Nonetheless, certain precautionary legal measures are advisable, and recommendations in this regard have been laid out elsewhere (Kapp, 1984).

This chapter begins with a general overview of nursing home law. This is followed by specific attention first to the matter of residents' rights and then to the question of decisionmaking for nursing home residents. Finally, some modest speculation about the future of nursing home law is offered.

OVERVIEW OF NURSING HOME LAW

Sources of Nursing Home Law

Legal regulation of nursing homes derives from a variety of sources (Grimaldi, 1984). We utilize for this purpose state licensure statutes and reimbursement (primarily Medicare and Medicaid) certification requirements and surveys of both state and federal government (20 Code of Federal Regulations Part 405). Facilities seek voluntary forms of accreditation from private agencies such as the Joint Commission on Accreditation of Hospitals (Joint Commission of Accreditation of Hospitals, 1986), whose guidelines are frequently relied on by courts as legally enforceable industry standards. Internal and external utilization and quality assurance

mechanisms have proliferated. Several criminal prosecutions against nursing homes and their staffs have emerged in the last few years (Hamme, 1984).

Finally, and of growing importance in the long term care setting (Kapp, 1986; Kapp, 1987), there is the professional liability or malpractice claim. This is the individual civil lawsuit brought by or for an individual nursing home resident against one or a combination of institutional or individual providers.

Theories of Liability

The overwhelming majority of cases alleging nursing home wrongdoing fall on the civil (as opposed to criminal) side of the law. There are three primary areas of potential civil liability for nursing home malpractice (Douglas, Feinberg, Jacobson, et al., 1985): (1) Failure to obtain effective consent before intervening in the life of a resident; (2) breach or violation of a contract or promise; and (3) the rendering of substandard, poor quality resident care. Although these three legal theories are analytically distinct (that is, any one by itself may support a successful malpractice claim if properly substantiated), in actual practice, allegations regarding two or more of these grounds are frequently cited in combination by the plaintiff in the complaint against the caregiver. The legal implications of informed consent are mentioned later in this chapter. We focus in this section, therefore, on the legal principles surrounding malpractice lawsuits that are grounded on a claim of substandard care (which is the basis for most resident claims) or breach of premise.

A civil lawsuit predicated on the violation of some duty arising from a source other than a promise is called a tort. A tort may be either an intentionally committed or an unintentional, accidental wrong. The most common sorts of intentional torts in the nursing home environment are fraud

and battery, the latter term referring to the unconsented-to offensive touching of another person. Most tort complaints in the health care arena, though, rely on claims of unintentional, accidental misdeeds, or negligence.

In a typical malpractice lawsuit based on allegations of substandard care, the plaintiff must prove each of four elements in order for professional liability to be found (King, 1986). Failure to establish any one of these defeats the plaintiff's entire claim. The four elements are: (1) Duty; (2) Breach or Violation of that duty; (3) Damage or Injury; and (4) Causation. A helpful pneumonic device for remembering these elements is the Law of D Cubed--A Dereliction of Duty must Directly Damage.

A nursing home's duties toward residents derive from two separate sources: (1) the fiduciary or trust nature of the provider/resident relationship, which gives rise to the tort liability just discussed, and (2) promises made by the nursing home directly to the resident, to the resident's representative (such as a family member or agency sponsor), or to some other third party (such as a state Medicaid agency), where the resident is the intended beneficiary of the promises (Wynn, 1979).

A legally enforceable promise may be either express or implied. An express promise is one that has been put into words, either written or oral. An implied promise is one that may be indirectly, but logically and reasonably, inferred by the resident based on the nursing home's words or actions (Chapman, 1982).

In health care generally, most express promise lawsuits have involved alleged guarantees to the patient about particular results, treatment methods, or professional participants in that patient's care. Such matters are beyond the absolute control of the provider, and therefore guarantees concerning such matters should never be conveyed, and certainly never put in

writing. Lawsuits based on these types of promise have been rare in the nursing home context. However, the variety of provider promises commonly found in the written Admission Agreements that are prevalent in nursing homes (Brown, 1985; Harris, 1986; Leonard, 1982), as well as in advertisements and distributed informational and promotional materials, provide the aggrieved resident with a fertile source of potential breach of contract claims.

A number of implied promises may be teased out of any health care provider/patient relationship. Most important, and always present, is the provider's implied promise or warranty to use due or reasonable care under the circumstances in rendering services to the patient (Brown, 1975; Regan, 1979).

A malpractice lawsuit, thus, may be brought on an intentional or unintentional (negligent) tort basis, a contractual basis, or both bases simultaneously. In other words, a plaintiff may plead (make formal accusations of) malpractice ex delicto (based on the wrong) or ex contractu (based on the promise), or both.

Personal, Vicarious, and Corporate Liability

A variety of parties form a variety of relationships with nursing home residents, and consequently owe certain responsibilities to those residents for which the parties may be held legally liable. These parties may include: (1) employees or volunteers of the nursing home, (2) governing board members (Bird, 1983), (3) physicians and other independent health professionals (e.g., podiatrists and dentists) with admitting and/or treatment privileges in the facility, (4) laboratories, pharmacies, and other independent corporations with which the nursing home contracts for

goods and services, (5) students who are placed within the nursing home for learning experiences, and (6) the nursing home itself.

In a malpractice lawsuit initiated by or on behalf of a resident, it is conceivable that any or all of these parties might end up being named as defendants (either by the plaintiff in the original complaint or by the original defendants in a cross-complaint). In this context, a party may be exposed to potential liability, depending on the facts, either (1) personally, (2) vicariously, or (3) corporately.

Personal liability is the doctrine that holds an individual responsible for what he or she personally does or does not do. Each of us may be held accountable for our own acts or omissions. For example, a physician who prescribes the wrong drug or dosage for a resident may be found personally liable for that wrongful act (assuming that it directly resulted in injury).

In addition to (not in place of) claims that may arise from an individual's personal conduct, that individual's supervisors and the nursing home itself may also face vicarious liability for the individual's misconduct. Under the principles of "agency," which is the part of contract law that embodies the concept of "master" (employer, supervisor, principal) and "agent" (employee, supervise, agent), a "master" is civilly liable for injuries to the person or property of third persons occasioned by the tortious negligence of a "servant" that occurred within the scope of that "servant's" employment or responsibilities. This doctrine is referred to as "respondeat superior."

The vicarious liability doctrine applies with full force in the health care context generally (King, 1986; Richards and Rathbun, 1983), and regarding nursing homes particularly (Goldberg, 1983). Hence, if an agent

or "servant" commits a tortious act or omission in the course of performing assigned duties, the facility itself may be held liable.

Respondeat superior, although no-fault from the supervisor's and facility's vantage point, is not exclusively a form of strict or absolute liability, since some substandard conduct by a subordinate is requisite in order to activate the liability of the supervisor or facility. Specifically, a supervising health care professional or institution may not be held legally liable for the misdeeds of a subordinate unless a jury finds as a matter of fact that the subordinate rendered negligent care that proximately caused a resident to suffer compensable injuries.

Hence, the nursing home, as a large-scale employer and principal, must properly supervise the activities of its employees and agents. With regard to its staff, the nursing home assumes a legal duty to provide adequate training and supervision. The need to hire and train a qualified staff and maintain a program of monitoring performance cannot be overstated . This need extends to both professional staff and to non-professional employees, as long as they perform (as does virtually everyone who works in a nursing home) tasks that in any way impact on resident welfare. Similarly, appropriate care in the selection, training, and oversight of the nursing home's volunteers, agents, and students is equally essential.

Vicarious liability is called a "derivative" form of liability, because it derives from and depends on the relationship between the party in the superior position and the subordinate who was personally at fault. In addition to legal exposure under the vicarious liability doctrine, a health care facility such as a nursing home may also be held legally liable to a patient <u>directly</u>, that is, based on its own relationship to the resident. A

nursing home's own direct liability to an injured resident rests on the theory of corporate or institutional liability (Frantz, 1978; Davidson, 1971).

The corporate or institutional liability theory imposes on a nursing home a variety of specific duties. The basic categories into which these duties fall include (Peters and Peraino, 1984; Southwick, 1978):

1. The duty to properly maintain buildings and grounds in a safe condition.

2. The duty to properly purchase and maintain equipment, supplies, medication, and food.

3. The duty to develop and implement appropriate written institutional policies regarding resident safety.

4. The duty to carefully screen, train, monitor, and supervise facility employees, volunteers, and students.

5. The duty to carefully screen, monitor, and supervise independent contractors with whom the nursing home has a business relationship. Most notable as members of this category are private physicians with admitting and treating medical staff privileges at the nursing home. (Of course, physicians who are actually employed by the nursing home, on a full or part-time basis, expose their employing institution to vicarious liability under respondeat superior).

This last type of duty is the most challenging for a nursing home to properly fulfill. It encompass, at the least, (a) a duty to determine the professional competence and character of a physician before granting staff privileges; (b) a duty to evaluate the continuing professional competence and performance adequacy of a physician before the periodic renewal of

privileges; and (c) the duty to conduct ongoing assessments of their physicians' competence and performance (Goldberg, 1984).

RESIDENTS RIGHTS

As explained earlier, legal liability may occur when a nursing home violates a responsibility that it owes to a resident. Every nursing home has a responsibility to respect and protect the rights of all of its residents, and to develop and implement policies and procedures that ensure the protection of those rights, consistent with the protection of the rights of others and the operation of a safe and caring health care facility (Harris, 1985).

Sources of Rights

Resident rights, and accompanying nursing home obligations, derive from several legal sources. Among the most important of these sources is the common law--that is, judge-made law, evolving over time through individual case decisions, based on our society's history, culture, and values. Common law principles have evolved in the United States to protect and promote respect for the autonomy, integrity, self-determination, and dignity of all individuals, including (perhaps especially) vulnerable nursing home residents, and imposing a responsibility on those in a fiduciary relationship to fulfill those rights.

Another major source of nursing home resident rights is specific statutes (laws promulgated by administrative or executive agencies, such as a health department). Applicable statutes and regulations are in force on both the federal and state levels.

On the federal level, regulations called the Conditions of Participation set minimum requirements for all Skilled Nursing Facilities that receive financial reimbursement from the Medicare (Title 18 of the

Social Security Act) and Medicaid (Title 19) programs and all Intermediate Care Facilities that participate in the Medicaid program. The Conditions of Participation for both Medicare and Medicaid contain sections specifically on resident rights (Wilson, 1978). These sections are frequently referred to as the Patient Bill of Rights. The federal government also issues Interpretive Guidelines to these regulations, which are distributed to inspectors who survey nursing homes for compliance with the regulations and are available to the public. In late 1985, the federal government instituted the Patient Care System (PaCS) methodology for measuring compliance with its regulations.

In addition to the federal regulations, many states have enacted their own statutes or regulations attempting to ensure the rights of their own nursing home residents (Opperman, 1981; Phillips, 1980; Silfen, 1980). Compliance with such state Patient Bill of Rights statutes and regulations is tied to mandatory facility licensure, as well as state Medicaid reimbursement for indigent residents. These state laws take from and build on the federal law, but many of them set up more stringent demands than their federal counterpart; where a difference between the federal and state requirements on a particular point arises, it is the more stringent provision that is enforced. Many state statutes expressly create a private right of action by the resident to enforce the rights contained in the statute (American Bar Association, 1981; Hoffman and Schreier, 1981).

Another arguable source of resident rights is the federal constitution, particularly the Due Process clauses of the Fifth and Fourteenth Amendments, and the federal Civil Rights statute (Title 42, United States Code, Section 1943,), which authorizes private lawsuits by individuals for alleged

violations of one's constitutional rights where the violations occur "under color of state law" (Regan, 1977). An increasing number of lawsuits by or for residents may be based on this ground.

Resident rights may also emanate from obligations that the nursing home voluntarily agrees to undertake as conditions of the admission agreement made between the nursing home and the resident. This is a contractual source of resident rights.

Standards of the Joint Commission on Accreditation of Hospitals may also serve as the source of resident rights. As a requirement for JCAH accreditation (which is voluntary), compliance with the resident rights section of the JCAH Accreditation Manual for Long Term Care Facilities is mandatory. In a lawsuit brought against a JCAH-accredited nursing home, a resident may introduce at trial as evidence of the applicable legal standard of care a copy of the JCAH provisions that the nursing home voluntarily agreed to obey.

Finally, voluntarily-adopted, written internal institutional policies and procedures regarding resident rights and grievance/complaint resolution (American Health Care Association, 1981; Phillips, 1980; Wilson, 1978) may be used as evidence to help prove the professional standard of care to which the nursing home and its staff should be held answerable. Once a nursing home has agreed to live by certain rules--even if those rules are internally rather than externally imposed--residents have a legally protectable right to expect that the rules will be followed and the opportunity to seek redress when they are not.

Substantive Provisions

Specific resident rights protections may vary from jurisdiction to jurisdiction and facility to facility, depending on the particular

applicability of the sources of rights that are discussed above. One must become thoroughly familiar with the specific provisions in force in any nursing home with which that person is affiliated.

Despite some variability, the fundamental types of resident rights that any nursing home in the United States today must honor may be roughly catalogued into these basic categories (Buford, 1984):

--The right to be treated fairly, without discrimination

--The right to voice concerns and to have complaints resolved

--The right to be informed of costs and charges (Caldwell and Kapp, 1981)

--The right to be informed about, and to participate in, decisions about care and treatment

--The right to choose the source of services and supplies

--The right to manage personal financial affairs

--The right not to be unfairly transferred or discharged

--The right to be free from unreasonable restraint

--The right to privacy, including privacy with a spouse or other sexual partner (Seyle, 1985)

--The right not to be required to perform services

--The right to communicate and associate with others

--The right to use personal clothing and keep personal possessions (Timmreck, 1983)

--The right to participate in a Resident Council

--The right to be treated with respect and dignity

--The right not to have confidential information revealed

Advocacy

Increasingly, nursing homes must interface with various forms of resident rights advocacy efforts. Rights advocacy for nursing home residents may take the form of: (1) self-advocacy (e.g., Resident Councils--Raper, 1982; Devitt and Checkoway, 1982); (2) legal advocates (Regan, 1977); (3) ombudsmen (Doty and Sullivan, 1983; Monk, Kaye, and Litwin, 1984); and (4) family and other friendly visitors. While advocacy sometimes takes on an adversarial, confrontational posture, ideally a nursing home working in harmony with resident rights advocates can achieve an enhancement in the quality of resident lives without endangering the legal health of the facility or its staff.

DECISIONMAKING FOR NURSING HOME RESIDENTS

Nursing home residents face important decisions every day of their lives (Doudera, 1985). These decisions may concern matters of mundane living, such as what clothes to wear, what food to eat, what television show to watch, and in what activities to partake. These decisions may also involve difficult and fundamental medical issues, such as which physician to select (Lehrer, 1985), whether to take one's medicine, whether to submit to a transfer to an acute care hospital so that aggressive life-sustaining treatment may be initiated, whether to permit intravenous feeding tubes to be inserted in oneself, whether to assent to the imposition of restraints or room transfers, or whether to agree to behavior control interventions such as electroconvulsive therapy (ECT).

Competent Residents and Informed Consent

As a general legal principle, such decisions should regularly be made by the person most directly affected by the consequences of that decision. This doctrine of Informed Consent is fully applicable to adult nursing home

residents (Goldberg, 1983). Requirements concerning informed consent for nursing home residents stem not only from common law court decisions, but also from federal and state statutes and regulations and various voluntary guidelines.

The first requirement for a valid legal consent is that the resident's participation in the decisionmaking process and ultimate decision must be voluntary. The usual definition of voluntariness in the context of consent is that the person giving or withholding consent must be "so situated as to be able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion" (Turnbull, 1977). It means simply that the person must be free to reject participation in the proposed intervention. The nursing home must do all that it can to minimize any coercion inherent in the facility/resident relationship, and to make sure that advice and recommendations are transmitted to the resident in as nonpressured and empathetic a manner as possible. Such a practice best respects the dignity of the resident as a human being, promotes the therapeutic value of the alternative selected, and protects the legal flanks of the nursing home and its professional staff.

The second essential requirement for valid consent is that the resident's agreement be informed. The legal doctrine of informed consent requires that the service provider, before undertaking an intervention, disclose certain information to the individual who is the subject of the proposed intervention.

The disclosure standard currently enforced in the majority of American jurisdictions is referred to as the "professional," "reasonable physician" (Rosoff, 1981; Rozovsky, 1984), or "community" (Christoffel, 1982)

standard. Under this test, the adequacy of disclosure is judged against the amount and type of information that a reasonable, prudent health care professional would have disclosed under similar circumstances.

A growing, although slowing (LeBlang, 1983), minority of jurisdictions have accepted a more expansive standard of information disclosure: the "reasonable patient" or "material risk" standard (Miller, 1980; Rosoff, 1981; Rozovsky, 1984). This standard dictates that the health care professional communicate the information that a "reasonable patient" in the same situation would need to make a voluntary and intelligent decision. Under this test, the resident must be told about all material risks--that is, those factors that might make a difference to a reasonable, average resident under similar circumstances.

The age of a resident may be relevant in affecting what information is material to that resident's decisionmaking (Schwartz, Nathanson, Hardwick, et al., 1984). For instance, a likely side effect that will not manifest itself for another twenty years probably will not be very important to an older person. However, the probability that a particular intervention will be accompanied by a great amount of physical pain or discomfort may make quite a difference to an old, frail nursing home resident. Physicians and other health care professionals should always consider the physical and mental effects of aging, among numerous other factors, when deciding whether information regarding an intervention might be material to the specific individual.

Within these standards of disclosure, the specific informational items have usually been enumerated as follows (Gregory, 1981): (1) Diagnosis; (2) Nature and purpose of the proposed intervention; (3) Risks, consequences, or

perils of the intervention; (4) Probability of success; (5) Alternatives; (6) Result anticipated if nothing is done; (7) Limitations on professional or facility; and (8) Advice.

The connection between information disclosure and the prevention of lawsuits is clear. Talking with (but not at) residents and their families--often, informatively, and compassionately--contributes mightily to a sense of resident satisfaction and well-being. Technical legal doctrine aside, fostering the resident and family's attitude that the health care professional cares deeply enough to relinquish some of his or her own traditional power and involve them meaningfully in the decisionmaking process is the best form of risk management achievable (Wadlington, 1984). It is preferable for all concerned that information be timely and appropriately discussed, rather than that its nondisclosure subsequently have to be defended.

The third essential element of legally effective consent is that the resident must be mentally competent to think rationally regarding personal care. Where the resident lacks sufficient mental capacity, a substitute or proxy decisionmaker must be involved. Incapacity and questionable capacity of residents is a fundamental and widespread issue for every nursing home.

Determinations of Competency

Despite the strong legal presumption toward respect for the individual resident's autonomous right to make decisions concerning his or her own life, including choices about medical treatment and financial management, for a significant proportion of nursing home residents the capacity to make and express legally valid decisions has been compromised by biological factors (e.g., dementia, chronic brain syndromes, stroke, depression) and by the environment in which they find themselves. Even the best nursing home,

where resident rights are assiduously respected, may--simply by virtue of being a total institution--exert a debilitating influence on the resident's sense of control (White and Janson, 1985). The combination of illness and institutionalization may substantially impair the ability to make and communicate autonomous choices on important matters.

Legal competency refers to a relative, rather than an absolute, degree of ability scale (Tepper and Elwork, 1984). To say that a person is legally incompetent implies that the individual is below some minimum level of capacity and rage of opportunity, and not simply that the person has less capacity and opportunity than certain other people (Miller, 1982).

While courts generally (in the minds of critics of the guardianship system too routinely) grant petitions for appointment of substitute decisionmakers for elderly nursing home residents (as well as older community-dwellers), in seriously contested cases there is a strong judicial preference for and deference toward letting older persons make and live (or die) with their own decisions (Douglas, Feinbert, Jacobson , et al., 1985). However, the great majority of situations where the decisionmaking capacity of a resident is called into question is handled on a de facto rather than de jure basis. That is, most such cases are quite properly--and without adverse legal consequences--managed by the nursing home, usually in conjunction with the family, without formal court involvement in deciding and acting upon the resident's decisionmaking impairment.

In most circumstances, competency should be addressed as an ethical matter by those who are closest to the resident, and resort to the courts is neither necessary nor desirable, since it is expensive, time-consuming, and emotionally draining. Initiation of judicial involvement in competency determinations should be the exception instead of the rule. It will depend

on a variety of factors in any case, but elements that might point toward the advisability of advance formal legal clarification include (American Hospital Association, 1985): (1) the incapacity is great and likely to be prolonged, and there is no obvious surrogate; (2) the capacity of the resident is questionable, and the decision to be made is significant; (3) the views of the surrogate are strongly at variance with medical judgment or the resident's known views; or (4) the choice of the individual to serve as surrogate is controversial and all efforts to resolve the matter at the nursing home level have failed; and (5) family members radically disagree about the course of action for a resident who lacks adequate decisionmaking capacity.

In some situations, such as the resident in a long-term coma or a persistent vegetative state (PVS), the determination of incompetence is fairly straightforward. In most circumstances, though, clinical presentations of potential incompetence are more cloudy: transient incapacity, due to acute illness or medication side-effects; mental retardation; mental illness or emotional problems; or physical handicap (Munetz, Lidz, and Meisel, 1985). Much more is entailed in determining legal status than simple diagnostic labelling of a clinical condition.

There exists no single, uniform standard of competence. Instead, competence to engage in decisionmaking has been only rarely and vaguely defined in statutes and court decisions. In daily practice, it is frequently the attending physician acting alone, in his or her sole discretion, who decides when a person is not capable of making decisions and a substitute should be involved, without any explicit standards for that determination being employed.

In determining competency, the most thoughtful analyses urge that emphasis not be placed on the "objective" nature of the resident's clinical diagnosis or on the specific choice made by the resident, but rather on the capacity of the resident and the subjective thought process followed in arriving at a "good" or "bad" decision (Jonsen, Siegler, and Winslade, 1982; Meisel, Roth, and Lidz, 1977). The focus is on functional ability.

Under a functional inquiry, the fundamental questions suggested are these: (a) Can the person make and communicate (by spoken words or otherwise) (Steffen and Franklin, 1985) choices concerning his or her own life? (b) Can the person offer any reasons for the choices made? (c) Are the reasons underlying the choice "rational"? For instance, the person who declines amputation of a gangrenous leg because she does not wish to continue living with only one leg is acting more rationally than someone making the same decision out of fear that with an amputation she will not be able to run away from invading Martians fast enough; (d) Is the person able to understand the implications (i.e., the likely risks and benefits) of the alternatives presented and the choices that are made, and the fact that those implications apply to that person? (e) Does the person actually understand the implications of those choices for him or her? (Gutheil and Appelbaum, 1982; Meisel, 1981; Roth, Meisel, and Lidz, 1977).

Under this functional approach, the resident need not understand the scientific theory underlying the physician's recommendations in order to be deemed competent, as long as the resident comprehends the general nature and likely consequences of the choices presented. Also under this approach, competency must be determined on a decision-specific basis; that is, a resident may be capable of rationally making certain sorts of decisions, but not others (Culver, 1985). The minimally necessary degree of intellectual

and emotional capacity may be visualized as falling somewhere on a sliding scale that depends on the nature of the decision being faced (Drane, 1984; Drane, 1985; Harris, 1985). Thus, competency should not be treated as an all-or-nothing affair. Partial competence is not the same thing as incompetence. The resident may be competent "enough" to make the decision in question.

Additionally, competency may wax or wane for a particular resident according to environmental factors, such as (a) time of day, (b) day of the week, (c) physical location, (d) acute, transient medical problems, (e) other persons involved in supporting or pressuring the resident's decision, or (f) medication reactions. Health care providers are under an obligation to manipulate, wherever possible, environmental barriers to capacity in an attempt to maximize the decisionmaking capacity of a resident. Thus, if a decision can be delayed until a resident is in a more lucid phase, or medications can be altered to allow the resident a clearer head to contemplate choices, this is preferable to proceeding unnecessarily on the basis of substituted decisionmaking. Also, many acute physical or mental problems of elderly residents impinging on decisionmaking capacity can be successfully medically treated, and that course should be vigorously pursued before considering the resident incompetent.

Many elderly nursing home residents are capable of "assisted" consent with a little extra time and effort on the part of health care providers (Schwartz, Nathanson, Hardwick et al., 1984). For example, an elderly resident, although not able to process complex information as swiftly and efficiently as a younger person, may nevertheless be able to understand the complexities of a proposed treatment if given enough time to fully process the information. Health care professionals should be aware that elderly

patients may need more time to work through complex information regarding treatment and should not automatically equate the speed with which an elderly resident processes information with the level of competency of that resident.

Proxy Decisionmaking for Incompetent Residents

Where it has been determined that a resident lacks sufficient capacity to independently make legally binding life choices, an acceptable means of substitute decisionmaking must be achieved, both to protect the well-being of the resident and the legal security of involved health care professionals and institution. Alternative ways of delegating what would ordinarily be the resident's authority to make decisions to someone else, to exercise that power on behalf of the resident, may be categorized as follows: (a) Delegation of authority beforehand by the resident himself or herself, through methods of advance planning; (b) Delegation of authority to a substitute by operation of statute, regulation, or broad judicial precedent; (c) Informal delegation of authority to a substitute by custom; and (d) Delegation of authority to a substitute by a court order in the specific case.

The two most important current devices for advance health care planning are the living will and the durable power of attorney for health care. In addition to allowing a person to give specific advance directions concerning his or her medical treatment in the event of subsequent mental incapacity and terminal illness, the living will in a number of states is a permissible mechanism for designating another individual to act as the proxy or substitute decisionmaker to represent one and act on one's behalf in the

event of later incompetence and terminal illness. As of 1986, thirty-seven states had statutes specifically authorizing the execution of a living will. The durable power of attorney is a legal document in which an individual may direct, through the appointment of an agent who is given either general or specific instructions, the making of medical decisions and the management of property in case of future incapacity.

In some circumstances, authority may devolve or pass from the resident to someone else by operation of a statute, regulation, or judicial precedent. Probably the best known example of this form of substitute decisionmaking is the representative payee concept. This entails the appointment of a proxy for a person who is receiving certain regular government benefit payments, including pension and disability checks from the Veterans Administration, Department of Defense, Railroad Retirement Board, and Civil Service. Most significant in this regard are Old Age, Survivors, or Disability Insurance (OASDI) benefit payments under Title 2 of the Social Security Act and Supplemental Security Income (SSI) benefit payments to the Aged, Blind, or Disabled under Title 16 of the Social Security Act.

Apart from the handling of government benefit payments, the federal Medicare/Medicaid Conditions of Participation provide (20 Code of Federal Regulations Section 405.1121 (k)) that the rights of a resident who is (1) adjudicated incompetent in accordance with State law or (2) found, by his physician, to be medically incapable of understanding his or her rights, devolve to the resident's guardian, next of kin, sponsoring agency(ies), or representative payee. Ironically, in a growing number of jurisdictions, it is in the area of decisionmaking about care of the terminally ill resident that statutory, regulatory, and judicial guidance about substitute

decisionmaking is clearest. Living will statutes in nine states set forth procedures for decisionmaking on behalf of incompetent persons who have not signed a living will or durable power of attorney (Society for the Right to Die, 1985). The procedure consists of unanimous agreement between attending physician, specified relatives (usually in a stated order of preference), and sometimes consultant physicians as well. The trend in enactment and modification of living will legislation in other states also seems to be in this direction. In addition, courts in an increasing number of states are formally recognizing the authority of the family to exercise the incompetent person's rights on his or her behalf.

As a general matter, in the absence of a specific statute, regulation, or court order delegating authority to a substitute decisionmaker, or a court order finding an individual mentally incompetent and appointing another specific person to act as guardian or conservator, neither the family as a whole nor any of its individual members (nor anyone else) have any special legal authority to make decisions on behalf of a resident who cannot speak for himself or herself. Nevertheless, it has long been the widely known and implicitly accepted medical custom or convention to rely on families as decisionmakers for incompetent persons, even in the absence of express legal power (Fowler, 1984; Tibbles, 1985). Even where there is no explicit judicial or legislative authorization in one's own state, the legal risk of a nursing home or its professional staff for a good faith treatment decision made in conjunction with an incompetent resident's family is very slight.

In some cases, however, informal substitute decisionmaking by family members may not work (Harzen, 1986). The family members may disagree among themselves. They may make decisions that seem to be at odds with the

earlier expressed or implied preferences of the resident, or that appear not to be in the resident's best interests (e.g., financially motivated selfish choices). The family may request a course of conduct that seriously contradicts the facility's or physician's own sense of ethical integrity. When such situations occur, judicial appointment of a guardian or conservator empowered to make decisions on behalf of an incompetent ward may be practically and legally advisable.

Every nursing home should write and adopt a clear institutional policy concerning guardianship for its residents. This policy should cover at least the following issues: (a) When the nursing home will initiate proceedings; (2) When the nursing home will request the family to initiate proceedings; (3) Institutional ascertaining and monitoring of performance by a resident's guardian (e.g., Is the guardian properly following what the resident's wishes would be, or at least acting in the resident's best interests?); (5) When the nursing home will initiate judicial intervention into a resident's guardianship that is not working properly (e.g., where the nursing home has reason to believe that the guardian is not acting in the resident's best interests); and (6) The very limited circumstances in which the nursing home itself will agree to act as a resident's guardian.

"DO NOT" ORDERS

Decisions to withhold or withdraw certain types of medical interventions from a resident are often made prospectively, and are stated as "Do Not" orders from the attending physician to other members of the care team. Most attention has been devoted, especially in the acute hospital environment, to "Do Not Resuscitate" (DNR) orders (also known as "No Codes"), or instructions by the physician to refrain from attempts at cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest. DNR

orders are a relevant issue in nursing homes, where cardiac arrests are not an unusual event. However, given the technological and staffing composition and limitations of most nursing homes, plus the physical and mental status of many nursing home residents, other kinds of "Do Not" orders take on greater importance in the long term care setting (Besdine, 1983). Most significant are potential "Do Not Hospitalize" (DNH) and "Do Not Treat" (DNT) orders.

Legally, deciding about and implementing "Do Not" orders should be handled according to the same substantive principles and procedural guidelines as apply to other treatment decisions (Robertson, 1983). In fact, by allowing and encouraging certain decisions to be made prospectively, before a crisis develops, "Do Not" orders may reduce potential legal risk and legal anxiety.

The legal status of "Do Not" orders where the resident is mentally competent is fairly unambiguous. It parallels the situation for medical intervention generally, including that which would be life-prolonging or even lifesaving. In other words, a competent resident has the right to voluntarily and knowingly refuse CPR, hospitalization, or any other form of medical intervention, and to demand that he or she be the recipient of a "Do Not" order. This fundamental right may be overridden only by a judicial determination that there exits, in the particular circumstances, a state or societal interest that is compelling enough to justify infringing on the resident's autonomy. The wishes of close family members should be considered, but should never be permitted to override the decision of a competent resident.

First, each nursing home should have a written policy statement regarding its institutional philosophy and technological and staffing

capacities (and limitations) concerning various "Do Not" situations (Miles and Ryden, 1985; Task Force on Supportive Care, 1984; Hoyt and Davies, 1984). Second, a copy of this statement should be presented to every competent prospective resident and his or her family at or before the admission interview. Third, extensive and regular staff education should be carried out concerning the provider's policies in this area. Fourth, the nursing home, through its medical staff bylaws and other means, should strongly encourage medical staff members and nurses to discuss openly and honestly treatment preferences and objectives with residents who are capable of participating in such decisions. Health care professionals should be required to document products of these discussions that might provide useful evidence later on of the resident's wishes and the good faith of the decisionmaking process. Some commentators have suggested that patients entering an acute hospital be given a questionnaire or other instrument at the time of admission to survey attitudes toward certain types of medical interventions (Stephens, 1986); this is an idea that nursing homes might want to consider.

Where a competent resident has made a "Do Not" decision, he or she must be able to continually re-evaluate and re-assess that decision in light of any change in physical or mental condition that materially affects the possible benefits or burdens of different treatment alternatives. A "Do Not" decision can be revoked or modified at any time. It is the duty of the involved health care professionals to continually supply the resident with any new information pertinent to "Do Not" decisions.

For the mentally incompetent resident, the situation is a bit more clouded legally. Clarification of respective rights and responsibilities

may be available from the resident's previously executed advance directive or a legislatively or judicially designated proxy. In the absence of such clarification, "Do Not" orders are still permissible for incompetent residents according to the same general life-prolonging treatment decisionmaking principles.

The suggestions offered above concerning the nursing home's responsibility to adopt, educate about, and communicate concerning a clear policy on "Do Not" orders applies with full force where incompetent residents are involved. Where a resident is not capable of participating in decisionmaking, the communication about potential "Do Not" management strategies must encompass available, interested family members. The family has no greater or less legal authority to make "Do Not" decisions for an incompetent relative than exists for other types of medical decisions. Even in the absence of specific legal authorization, in this sphere as elsewhere, it is (or should be) the medical custom or convention to involve families in "Do Not" decisions. From a practical, risk management perspective, extensive interaction with family members concerning such decisions is a prudent, protective practice. Conversely, even where the family lacks formal legal power to veto a physician's "Do Not" decision, proceeding with a "Do Not" order in the face of family opposition entails, from a practical standpoint, an unnecessary risk of legal challenge.

During communication with the family, questions should be encouraged and answered candidly. The communication responsibility falls primarily on the attending physician's shoulders, but other health care professionals can play a vital supportive role in this process. The physician should explain his or her reasoning, diagnosis, and prognosis, but may and should present

the family with a "Do Not" possibility in the form of a recommendation in which their agreement is sought. This helps to avoid putting the family in the position of feeling that they themselves made a decision that can afterwards cause them guilt and depression. When the physician explains why hospitalization, resuscitation, or some other medical interventions should not be attempted, the family members will rarely dissent if they have placed their trust in the physician (Spencer, 1979) and the nursing home. Where disagreement does surface and persist, avenues for resolving such disputes discussed earlier in this chapter remain available.

During the communicative process, the family should be informed that the appropriateness of a "Do Not" order will be continually re-evaluated, and that it can always be rescinded if prognosis or other factors change. A physician or nursing home could be found legally negligent for basing a "Do Not" order on an incorrect evaluation of the resident's condition and prognosis.

The attending physician should make liberal use of available professional consultations with relevant clinical specialists, while retaining ultimate medical control and responsibility over the case. The judgment of nurses and other members of the care team who are familiar with the resident should also be sought out and considered.

A number of state, local, and national medical societies, as well as ad hoc groups, have begun to address the legal and ethical implications of "Do Not" orders (President's Commission, 1983; Evans and Brody, 1985; American College of Emergency Physicians, 1985; Society for the Right to Die, 1985). Although such guidelines are at this point voluntary, rather than binding, they should carry weight with legislators, courts, medical staffs, and

facility governing boards who struggle with these issues. For this reason, as well as the ethical direction they may provide, health care professionals should keep abreast of, and involved in, the initiatives of their state, local, and national organizations in this sphere, as well as relevant ad hoc groups.

As advised above, every nursing home should have a clear, written policy statement dealing with "Do Not" situations. Medical staff should be knowledgeable of, and obedient to, that policy. The development and implementation of a formal institutional policy is an important step toward the establishment of a predictable and reasonable process for reaching a negotiated and informed decision, and eliminating surreptitious--and highly legally dangerous (American College of Emergency Physicians, 1985)--practices such as "Show Codes" or "Slow Codes," in which medical interventions are initiated, but less than wholeheartedly so that the person will die. Several model institutional policies from which administrators and governing boards may get ideas are available (Miles and Ryden 1985; Task Force on Supportive Care, 1984; Hoyt and Davies, 1984).

The nursing home policy statement should define important terms such as "terminal illness" and "imminent," and should address the legal, ethical, financial, and medical aspects of a "Do Not" order. The policy should contain as much specificity as possible; use of confusing and sloppy-appearing euphemisms like "comfort measures" or "supportive care" should be avoided unless accompanied by more precise explanations (Miles and Ryden, 1985). They carry the seeds of miscommunication and misunderstanding, and hence of legal difficulties.

The final document should reflect the nursing home's philosophy of resident care and should set forth at least the following: (1) explicit

requirements governing the practice of writing "Do Not" orders; (2) the respective roles of the resident (competent and incompetent), family, health care professionals, the nursing home (including its Institutional Ethics Committee, if extant), and other parties (e.g., nursing home Ombudsman); (3) the relationship of a particular "Do Not" order to the totality of the resident's care plan; (4) the appropriate professional standards applicable to "Do Not" orders; and (5) procedures to be used in resolving disputes arising among concerned parties (President's Commission, 1983).

Some uninformed health care professionals are still fearful that putting nontreatment decisions into writing in the resident's medical chart may increase their potential exposure to legal liability. This is a serious misperception (Hirsh, 1984). While a degree of sensitivity and discretion must be exercised (e.g., do not write the name of DNR residents on a blackboard in a public hallway), nontreatment decisions should be thoroughly documented (Evans and Brody, 1985).

The wishes of the resident, if ascertainable, the family, and significant others should all be recorded. The judgments of involved health care professionals, as well as their underlying reasoning, should be fully and candidly documented, as well as any attempts to change the minds of resident or family. Honesty and openness in recordkeeping in this sphere is the professional's best defense (as well as the nursing home's) against subsequent allegations of negligence or malevolent intent. Failure to put decisions and orders in writing not only fails to protect the health care professional, but invites inappropriate action by other team members based on the mixed and confused signals that are emitted.

This point needs to be underscored in the case of "Do Not" orders. THe JCAH, the American Medical Association (National Conference, 1980), the

President's Commission (President's Commission, 1983), and a division of the American Hospital Association (Read, 1983) have all carefully considered this issue and strongly endorsed policies mandating that "Do Not" orders be written directly by the attending physician in the medical record. Although the federal Medicare and Medicaid regulations and state nursing home laws do not expressly mention this subject, their general requirements for medical recordkeeping may fairly be interpreted to mandate that "Do Not" orders be written in the chart.

A written order serves to explain and justify the decision to withhold hospitalization, resuscitation, or other medical treatments and to avoid confusion and consequent improper action by other members of the health care team. The medical chart entry should contain the order itself, an enumeration of persons consulted, names of those who concurred in the decision, and the clinical facts and impressions supporting the order.

Once a "Do Not" order has been entered into a medical record, it should remain a permanent part of that record; if it is later modified or rescinded, the modification or rescission would also appear in the record.

Tied to the subject of documentation is the need for communication among health care professionals and institutions once a "Do Not" order has been written. Going through the agonizing process of decisionmaking serves little purpose if a decision to refrain from certain interventions is not communicated to those responsible for carrying out the "Do Not" orders, since, in the absence of such orders, the health care professional is obligated to treat the resident as aggressively as possible. Such communication is an institutional responsibility, and each nursing home should have a provision in its written policies detailing its procedure for

assuring that all members of the health care team involved with a particular resident will be accurately and timely informed of "Do Not" orders or other treatment limitations concerning that resident. Weekly interdisciplinary case reviews on each unit are one means of communication that should be considered. Special markings on the outside of the medical chart, discretely but clearly signifying particular treatment instructions, are also a valuable communicative tool.

There will be situations where a resident needs to be transferred to another health care institution (ordinarily an acute hospital) for treatment of a specific remediable problem (e.g., acute infection), but other treatment limitations may remain appropriate because of the resident's other, underlying, non-remediable deficits. In those circumstances, the nursing home should have a clear, effective, ongoing mechanism in place for communicating "Do Not" orders directly to health care professionals at the transferee provider who will be involved in the resident's care, as well as to professionals involved in the transportation of the resident between providers (Miles and Crimmins, 1985). Especially since medical staff in acute hospitals may have strong preconceptions about resuscitation and other aggressive therapy for older persons who reside in nursing homes (Farber, Weiner, Boyer, et. al., 1985), it is the nursing home's duty to timely transmit to the receiving health care provider, with or ahead of the resident, as much guidance as feasible concerning preferences, values, and instructions that should guide treatment for that person. There should be a written provision in the transfer agreement between the nursing home and any other health care institution for the communication of this sort of information.

Finally, as already alluded to, decisions to limit treatment should not signify total disregard or "writing off" of a resident. Neglect of continuing palliative care, as well as medical care that has not been the subject of a "Do Not" order, could alienate resident and family and expose the nursing home to charges of civil or criminal abandonment, neglect, or even abuse. Alleviating suffering is a basic goal of health care and a part of the standard of care legally and ethically owed by health care professionals and providers, even where "cure" of underlying disease is no longer possible (Besdine, 1983; Lynn, 1984). Management goals should consist of remaining in physical and emotional contact with the dying person; relieving terminal symptoms (such as pain, confusion, anxiety, or restlessness); providing nourishment and hydration, skin care, bowel and bladder care, and grooming; and supporting the family throughout the period of dying, death, and bereavement. High-dose narcotic agents and sedatives can be used despite the risk of suppressed cerebral function and respiratory depression because the therapeutic intention is to control the symptoms of human suffering, not to cause an earlier death (Rango, 1985).

FUTURE OF NURSING HOME LAW

Although the future of the law in any sphere, particularly one as rapidly changing as this, is always difficult to predict, several strong trends may be discerned. First, law-making and law-deciding bodies seem to be showing increasing deference toward mentally capable nursing home residents in permitting them to autonomously decide on their own course of medical treatment and other life choices. This is reflected in such developments as expansion of informed consent requirements, enhanced access to resident records, and encouragement of advance health care planning

through living wills and durable powers of attorney. At the same time, protections for residents who are incapable of making and communicating autonomous choices are getting more stringent, and nursing home accountability for its treatment of those residents more demanding. Concurrently, plaintiffs' malpractice attorneys appear to be just discovering nursing homes as a potentially fertile field for litigation efforts.

Nursing home law is, and will continue to be, dynamic. One possible blueprint for change that should be watched closely in the next few years is the recent study of nursing homes released by the National Academy of Science's Institute of Medicine (Institute of Medicine, 1986). This major project, funded by the federal Health Care Financing Administration as a prelude to regulatory action, recommended a number of significant legal modifications concerning nursing homes. Continuing vigilance and education for nursing home owners, administrators, and professional staff on legal matters affecting their practice is essential.

American Bar Association Commission on Legal Problems of the Elderly. MODEL RECOMMENDATIONS: INTERMEDIATE SANCTIONS FOR ENFORCEMENT OF QUALITY OF CARE IN NURSING HOMES. Washington, D.C. (1981).

American College of Emergency Physicians, "Medical, Moral, Legal, and Ethical Aspects of Resuscitation for the Patient Who Will Have Minimal Ability to Function or Ultimately Survive," 14 ANNALS OF EMERGENCY MEDICINE 919 (1985).

American Health Care Association, "Policy Paper: Patient's Rights," 7 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 55 (1981).
Statement of major nursing home trade association policy position on various aspects of residents' rights and facility responsibilities.

American Hospital Association. POLICY AND STATEMENT: THE PATIENT'S CHOICE OF TREATMENT OPTIONS. AHA: Chicago. Catalog No. 157628 (1985).

Besdine, R., "Decisions to Withhold Treatment in Nursing Home Residents," 31 JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 602 (1983), reprinted in Kapp, M., Pies, H., and Doudera, A.E. (eds), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY.
Health Administration Press: Ann Arbor, MI (1985).
Eloquent discussion of "Do Not" orders in the nursing home by a compassionate physician.

Bird, J., "Accountability and Liability," 6 CONTEMPORARY ADMINISTRATOR FOR LONG TERM CARE 46 (1983).

Brown, R., "Contract Rights and Rights Related to Admission, Transfer, and Discharge," 11 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 17 (1985).

Brown, R., "An Appraisal of the Nursing Home Enforcement Process," 17 ARIZONA LAW REVIEW 304 (1975).

Buford, A. RESIDENTS' RIGHTS: A MANUAL FOR LONG TERM CARE FACILITY ADMINISTRATORS AND SUPERVISORS. American Health Care Association: Washington, D.C. (1984).

Monograph by a leading advocate for the elderly commissioned by a major nursing home trade association discussing theoretical underpinnings and practical ramifications of implementing residents' rights in nursing homes.

Caldwell, J. and Kapp, M., "The Rights of Nursing Home Patients: Possibilities and Limitations of Federal Regulation," 6 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 40 (1981).

Two former Health Care Financing Administration officials speculate on the likely implications of regulatory changes proposed in 1980 (but never actually adopted).

Chapman, S., "Malpractice by Physician Assistants Can Involve the Physician," 21 PHYSICIAN'S MANAGEMENT 89 (1981).

Chapman, S., "Refusal of Consent: What the Doctor Must Do," 21 PHYSICIAN'S MANAGEMENT 84 (1981).

Christoffel, T. HEALTH AND THE LAW: A HANDBOOK FOR HEALTH PROFESSIONALS. Free Press: New York (1982).

Excellent introductory text for health care professionals and students on the impact of law on health care. This book is especially strong in the area of public health law.

Culver, C., "The Clinical Determination of Competence," in Kapp, M., Pies, H., and Doudera, A.E. (eds.), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY. Health Administration Press: Ann Arbor, MI (1985).

Article articulately discusses the criteria of decisionmaking competence, drawing the distinction between sufficient decisionmaking capacity, on one hand, and rationality, on the other.

Davidson, S., "Nursing Home Liability," 27 AMERICAN JURISPRUDENCE PROOF OF FACTS 623 (1971).

Devitt, M. and Checkoway, B., "Participation in Nursing Home Resident Councils: Promise and Practice," 22 GERONTOLOGIST 49 (1982).

Doty P. and Sullivan, E., "Community Involvement in Combating Abuse, Neglect, and Mistreatment in Nursing Homes," 61 MILBANK MEMORIAL FUND QUARTERLY/HEALTH AND SOCIETY 222 (1983).

Doudera, A.E., "Decisionmaking and Patients' Rights," 11 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 5 (1985).

Douglas, D., Feinberg, D., Jacobsohn , R., et al., "Rx for the Elderly: Legal Rights (and Wrongs) Within the Health Care System," 20 HARVARD CIVIL RIGHTS-CIVIL LIBERTIES LAW REVIEW 425 (1985).
Article ranging over a broad spectrum of legal aspects of elderly health care, written from an advocacy perspective. A good, if somewhat thin, introduction to the principle issues.

Drane, J., "The Many Faces of Competency," 15 HASTINGS CENTER REPORT 17 (1985).
Proposes a sliding scale for decisionmaking capacity, dependent on the difficulty and potential consequences of the particular decision.

Drane, J., "Competency to Give an Informed Consent: A Model for Making Clinical Assessments," 252 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 925 (1984).
An article very similar to the one listed immediately above.

Evans, A. and Brody, B., "The Do-Not-Resuscitate Order in Teaching Hospitals," 253 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2236 (1985).

Farber, M., Weiner, J., and Boyer, G., et. al., "Cardiopulmonary Resuscitation: Values and Decisions--A Comparison of Health Care Professionals," 23 MEDICAL CARE 1391 (1985).

Results of a study that primarily compared the attitudes of physicians and nurses toward CPR for severely debilitated patients.

Fowler, M., "Appointing an Agent to Make Medical Treatment Choices," 84 COLUMBIA LAW REVIEW 985 (1984).

Superb analysis of the use of durable power of attorney for health care.

Frantz, L., "Patient Tort Liability of Rest, Convalescent, or Nursing Homes," 83 AMERICAN LAW REPORTS 3d 871 (1978).

Goldberg, A., "PATIENT CARE DELIVERY IN NURSING HOMES: LEGAL ISSUES FOR OWNERS AND ADMINISTRATORS. American Health Care Association: Washington, D.C. (1983).

Small pamphlet by an attorney who represents nursing homes commissioned by a major nursing home trade association, briefly listing major legal issues and appropriate facility policy.

Goldberg, B., "The Duty of Hospitals to Regulate the Quality of Patient Care: A Legal Perspective," in Pena, J., Haffner, A., Rosen, B., and Light, D. HOSPITAL QUALITY ASSURANCE: RISK MANAGEMENT AND PROGRAM EVALUATION. Aspen Systems: Rockville, MD (1984).

Book chapter discussing the doctrine of 'corporate liability' as applied to health care.

Gregory, D., "Informed Consent: An Overview," 9 LEGAL ASPECTS OF MEDICAL PRACTICE 4 (1981).

Grimaldi, P., "How Major Regulations Strive to Ensure Quality Care in Nursing Homes," 38 HEALTHCARE FINANCIAL MANAGEMENT 50 (1984).

Gutheil, T. and Appelbaum, P. CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW. McGraw-Hill Book company: New York (1982).
Winner of the American Psychiatric Association's prestigious Guttmacher Award, this outstanding text by two brilliant forensic psychiatrists analyzes legal issues involved in providing psychiatric services or resolving psychiatric questions, such as decisionmaking competency.

Hamme, J., "Criminal Sanctions for Inadequate Patient Care," 7 CONTEMPORARY ADMINISTRATOR 17 (1984).

Harris, S., "Rethinking Admissions," 12 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 36 (1986).

Harris, S., "Fine-Tuning Risk Management," 11 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 51 (1985).

Harris, S., "Protecting the Rights of Questionably Competent Long-Term Care Facility Residents," in Kapp, M., Pies, H., and Doudera, A.E. (eds.), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY. Health Administration Press: Ann Arbor, MI (1985b).
Provocative report of a task force sponsored by a major nursing home trade association proposing multiple tests of decisionmaking competency, based on the nature of the decision in question.

Hirsh, H., "Verbal Orders: Perils and Pitfalls," 112 MEDICAL TIMES 15FM (1984).

Hoffman, A. and Schreier, K., "A Private Right of Action Under Missouri's Omnibus Nursing Home Act," 24 SAINT LOUIS UNIVERSITY LAW REVIEW 661 (1981).

Hoyt, J., and Davies, J., "A Response to the Task Force on Supportive Care," 12 LAW, MEDICINE AND HEALTH CARE 103 (1984), reprinted in Kapp, M.,

Pies, H., and Doudera, A.E. (eds.), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY. Health Administration Press: Ann Arbor, MI (1985).
Vigorous argument of nursing home residents' rights advocates for strong procedural safeguards before medical treatment is terminated from nursing home residents.

Institute of Medicine, National Academy of Sciences. IMPROVING THE QUALITY OF CARE IN NURSING HOMES. National Academy Press: Washington, D.C. (1986).
Extremely important report commissioned by the federal Health Care Financing Administration as a likely prelude to legislative and regulatory reform. Based on an extensive national study involving input from numerous interested individuals and groups.

Joint Commission on Accreditation of Hospitals (JCAH). ACCREDITATION MANUAL FOR LONG-TERM CARE FACILITIES. JCAH: Chicago (1985).
Standards developed by the most influential voluntary accrediting agency.

Jonsen, A., Siegler, M., and Winslade, W. CLINICAL ETHICS. MacMillan Publishing Company: New York (1982).
Pocket-sized text offers succinct advice on many ethical and legal dilemmas facing the modern physician.

Kapp, M. MALPRACTICE IN LONG TERM CARE: PREVENTIVE LEGAL STRATEGIES. Springer Publishing Company: New York (1987 In Press).
The first textbook designed specifically to guide nursing home owners, administrators, trustees, medical directors, staff physicians, nurses, and other long term care professionals in legal risk management techniques. Discusses the bases of nursing home liability and how to protect against their occurrence.

Kapp, M., "Preventing Malpractice Suits in Long Term Care Facilities," 12 QUALITY REVIEW BULLETIN 109 (1986).

Article summarizing some of the basic ideas contained in the textbook listed just above.

Kapp, M., "Nursing Homes as Teaching Institutions: Legal Issues," 24 GERONTOLOGIST 55 (1984), reprinted in Kapp, M., Pies, H., and Doudera, A.E. (eds.), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY. Health Administration Press: Ann Arbor, MI (1985).

Discussion of informed consent, standards of care, and confidentiality as these issues may arise in the context of the teaching nursing home. Suggestions for minimizing institutional legal risk engendered by educational affiliation agreements are included.

King J., Jr. THE LAW OF MEDICAL MALPRACTICE (2d ed.). West Publishing Company: St. Paul, MN (1986).

A paperback part of West's "Nutshell" series, designed mainly for law students and attorneys, but comprehensible to the non-law educated reader as well.

LeBlang, T., "Informed Consent--Duty and Causation: A Survey of Current Developments," 18 FORUM 280 (1983).

Leonard, L., "The Ties That Bind: Life Care Contracts and Nursing Homes," 8 AMERICAN JOURNAL OF LAW AND MEDICINE 153 (1982).

Lynn, J., "Care Near the End of Life," in Cassel, C. and Walsh, J. (eds.), GERIATRIC MEDICINE: FUNDAMENTALS OF GERIATRIC CARE, Volume II. Springer-Verlag: New York (1984).

Marzen, T., "Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach," 1 ISSUES IN LAW AND MEDICINE 293 (1986).

Article critical of informal decisionmaking mechanisms for the incompetent patient, and urging substantial legal involvement and procedural protection.

Meisel, A., "Informed Consent: Who Decides for Whom?" in Miller, M. (ed.), MEDICAL ETHICS AND THE LAW: IMPLICATIONS FOR PUBLIC POLICY. Ballinger Publishing Company: Cambridge, MA (1981).

Meisel, A., Roth, L. and Lidz, C., "Toward a Model of the Legal Doctrine of Informed Consent," 134 AMERICAN JOURNAL OF PSYCHIATRY 285 (1977).

Miles, S. and Crimmins, T., "Orders to limit Emergency Treatment for an Ambulance Service in a Large Metropolitan Area," 254 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 525 (1985).
Description of groundbreaking collaborative project in Minneapolis area dealing with non-resuscitation of hopelessly ill patients.

Miles, S. and Ryden, M., "Limited-Treatment Policies in Long-Term Care Facilities," 33 JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 707 (1985).
Description of groundbreaking collaborative effort in Minneapolis area dealing with No Code policies in nursing homes.

Miller, L., "Comparative Negligence," 248 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1443 (1982).

Miller, L., "Informed Consent I," "Informed Consent II," "Informed Consent III," and "Informed Consent IV," in 244 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2100, 2347, 2556, and 2661, respectively (1980).
Instructive series of articles on the rudiments of the informed consent doctrine.

Monk, A., Kaye, L., and Litwin, H. RESOLVING GRIEVANCES IN THE NURSING HOME: A STUDY OF THE OMBUDSMAN PROGRAM. Columbia University Press: New York (1984).

Munetz, M., Lidz, C., and Meisel, A., "Informed Consent and Incompetent Medical Patients," 20 JOURNAL OF FAMILY PRACTICE 273 (1985).

National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care, "Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)," 244 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 453 (1980).

Opperman, D., "Michigan's Bill of Rights for Nursing Home Residents," 27 WAYNE LAW REVIEW 1203 (1981).

Peters, J. and Peraino, J., "Malpractice in Hospitals: Ten Theories for Direct Liability," 12 LAW, MEDICINE AND HEALTH CARE 254 (1984).

Phillips, M., "Ohio's Bill of Rights for Nursing Home Patients," 5 UNIVERSITY OF DAYTON LAW REVIEW 507 (1980).

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT. U.S. Government Printing Office: Washington, D.C. (1983). This report is probably as close to a "state of the art" presentation of legal and ethical issues in terminating treatment for the dying as one currently will find.

Rango, M., "The Nursing Home Resident With Dementia: Clinical Care, Ethics, and Policy Implications," 102 ANNALS OF INTERNAL MEDICINE 835 (1985). A wide-ranging essay on various aspects of humane treatment of the demented nursing home resident.

Raper, A. RESIDENT DECISION-MAKING IN HOMES FOR THE AGING: A TECHNICAL ASSISTANCE MANUAL. American Association of Homes for the Aging: Washington, D.C. (1982).

Commissioned by the major trade association of not-for-profit nursing homes, this paperback manual explores practical methods for involving capable residents more in the running of their nursing homes.

Read, W., HOSPITAL'S ROLE IN RESUSCITATION DECISIONS. Hospital Research and Education Trust, Office on Aging and Long Term Care: Chicago (1983).

Position statement by American Hospital Association think-tank.

Regan, J., "When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate" 65 GEORGETOWN LAW JOURNAL 691 (1977).

A seminal discussion of nursing home advocacy by a pioneer in the field of law and aging.

Richards, E. and Rathbun, K. MEDICAL RISK MANAGEMENT: PREVENTIVE LEGAL STRATEGIES FOR HEALTH CARE PROVIDERS. Aspen Systems: Rockville, MD (1983).

Very fine text on risk management, concentrating exclusively on the acute care hospital.

Rosoff, A. INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS. Aspen Systems: Rockville, MD (1981).

Excellent, if now somewhat aging, text describing the informed consent doctrine and its application in specific circumstances.

Roth, L., Meisel, A., and Lidz, C., "Tests of Competency to Consent to Treatment," 134 AMERICAN JOURNAL OF PSYCHIATRY 179 (1977).

Seminal, widely cited article on criteria of decisionmaking competency.

Rozovsky, F. CONSENT TO TREATMENT: A PRACTICAL GUIDE. Little, Brown and Company: Boston (1984).

A comprehensive, probing dissertation on the informed consent doctrine and appropriate provider responses to its requirements.

Schwartz, R., Nathanson, P., Hardwick, J., et al., "Medical Treatment and Physicians' Legal Duties," in Cassel, C. and Walsh, J. (eds.). GERIATRIC MEDICINE: VOLUME II, FUNDAMENTALS OF GERIATRIC CARE. Springer-Verlag: New York (1984).

Seyle, J., "Privacy Rights and Rights Related to Physical Security," 11 AMERICAN HEALTH CARE ASSOCIATION JOURNAL 20 (1985).

Silfen, M., "Legislative Comment: Nursing Home Patients' Rights in Massachusetts: Current Protection and Recommendations for Improvement," 6 AMERICAN JOURNAL OF LAW AND MEDICINE 315 (1980).

Society for the Right to Die. THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT: LEGAL, MEDICAL AND ETHICAL GUIDELINES. New York (1985).
This small monograph is one of the best sources of information on the legal status of withholding or withdrawing medical treatment from the terminally ill currently available.

Southwick, A. THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION. Health Administration Press: Ann Arbor, MI (1978).
A classic, groundbreaking text in the interface of law and health care.

Spencer, S., "Code' or 'No Code': A Nonlegal Opinion," 300 NEW ENGLAND JOURNAL OF MEDICINE 138 (1979).
One of the earliest public discussions of the withholding CPR issue.

Steffen, G. and Franklin, C., "Who Speaks for the Patient With Locked-In Syndrome?" 15 HASTINGS CENTER REPORT 13 (1985).

Stephens, R., "'Do Not Resuscitate' Orders: Ensuring the Patient's Participation," 255 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 240 (1986).

Task Force on Supportive Care, "The Supportive Care Plan--Its Meaning and Application: Recommendations and Guidelines," 12 LAW, MEDICINE AND

HEALTH CARE 97 (1984), reprinted in Kapp, M., Pies, H., and Doudera, A.E. (eds.), LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY. Health Administration Press: Ann Arbor, MI (1985).

Position statement of Minnesota task force, proposing standards for withholding and withdrawing aggressive medical treatment from certain nursing home residents. Some residents' advocates attacked these standards as too liberal.

Tepper, A. and Elwork, A., "Competence to Consent to Treatment as a Psycholegal Construct," 8 LAW AND HUMAN BEHAVIOR 205 (1984).

Tibbles, L., "Derived Consent, Proxy Consent: Legal Issues," in Melnick, V. and Dubler, N. (eds.), ALZHEIMER'S DEMENTIA: DILEMMAS IN CLINICAL RESEARCH. Humana Press: Clifton, NJ (1985).

Discussion of the legal and ethical implications of conducting clinical research on human subjects of diminished competence.

Timmreck, T., "The Nursing Home Resident: Some Legal Considerations," 11 JOURNAL OF LONG-TERM CARE ADMINISTRATION 9 (1983).

Turnbull, H. CONSENT HANDBOOK. American Association of Mental Deficiency: Washington, D.C. (1977).

Written primarily for professionals serving the mentally retarded, this monograph is also relevant for those serving nursing home residents of compromised mental capacity.

Wadlington, W., "Breaking the Silence of Doctor and Patient," 93 YALE LAW JOURNAL 1640 (1984).

Excellent review of Jay Katz's book on communication, "The Silent World of Doctor and Patient."

White, C. and Janson, P., "Helplessness in Institutional Settings: Adaptation or Iatrogenic Disease?" in Baltes, M. and Baltes, P. (eds.), AGING AND THE PSYCHOLOGY OF CONTROL. Lawrence Erlbaum Associates: Hillsdale, NJ (1985).

Wilson, S., "Nursing Home Patients' Rights: Are They Enforceable?" 18 GERONTOLOGIST 255 (1978).

Concise exposition of the federal regulations governing residents' rights in skilled nursing facilities and intermediate care facilities.

Wynn, D., "Contractual Liability of Physicians: The Interface of Tort and Contract," 28 BUFFALO LAW REVIEW 625 (1979).